

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER Sundance Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2612 W Cucharras St Colorado Springs, CO 80904	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#1) of three residents reviewed for accidents received adequate supervision out of 14 sample residents. Specifically, the facility failed to ensure Resident #1 was not able to access hazardous chemicals. Resident #1, who was admitted to the facility on [DATE], had a history of dementia and of wandering within the facility. On [DATE] at 1:40 p.m., Resident #1 was able to obtain a bottle of a cleaning chemical that was located in a residential hallway on a maintenance cart that was unsecured and unsupervised. Resident #1 was found by certified nurse aide (CNA) #1 holding the bottle containing a cleaning chemical. Resident #1 was observed to have a blue substance on his lips, which was determined by the facility to be consistent with the contents of the bottle. Resident #1 was reported to have mouth and stomach pain after the incident. He was evaluated by a physician at the facility immediately following the incident and transferred to the hospital where additional evaluation was completed to determine if the resident had an esophageal (tube that runs from the throat to the stomach) injury, airway (breathing) compromise or electrolyte abnormality. Resident #1 was provided intravenous (IV) fluids and the hospital physician determined the resident likely had not ingested the toxic substance. Resident #1 was monitored at the hospital and returned to the nursing facility on [DATE]. The facility determined the product in the bottle was a cleaning product (Gel Pro). The material safety data sheet (MSDS - a document that describes the hazards of a chemical product and provides information on safe handling, storage, disposal and emergency procedures) revealed the product was reserved for industrial and professional use and if swallowed, required immediate medical attention. Ingestion of the product could cause digestive tract burns. Resident #1 experienced pain and required hospital evaluation to confirm he had not ingested a sufficient amount of the chemical to cause further injury. The facility's failure to ensure residents were not able to access hazardous chemicals placed Resident #1 and other residents at serious risk of harm, serious impairment or death if the situation were not corrected immediately. Findings include: Observations, record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on [DATE] to [DATE], resulting in the deficiency being cited as past noncompliance with a correction date of [DATE]. I. Situation of serious [NAME] [DATE] at 1:40 p.m., Resident #1 was able to obtain a bottle of a cleaning chemical that was located in a residential hallway on a maintenance cart that was unsecured and unsupervised. Resident #1 was found by CNA #1 holding the bottle containing a cleaning chemical. Resident #1 was observed to have a blue substance on his lips, which was determined by the facility to be consistent with the contents of the bottle. Resident #1 was reported to have mouth and stomach pain after the incident. He was evaluated by a physician at the facility immediately following the incident and transferred to the hospital where additional evaluation was completed to determine if the resident had an esophageal injury, airway compromise or electrolyte abnormality. Resident #1 was provided IV fluids and</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 065152	Facility ID: 065152 If continuation sheet Page 1 of 5

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1 said he had started to have stomach pain. RN #2 said she contacted Resident #1's representative about the incident and transfer to the hospital. RN #2 said the staff audited the building to be certain there were no hazardous items accessible to residents. The PCP was interviewed on [DATE] at 12:15 p.m. The PCP said on [DATE], a staff member notified him that Resident #1 had consumed drain cleaner. The PCP said he reviewed the MSDS for the product and contacted a poison control center. The PCP said he was told the resident had blue color on his lips, and he estimated the resident drank approximately 10 ml of the drain cleaner, based upon staff reports and the amount remaining in the bottle. The PCP said Resident #1 appeared stable, but was sent to the hospital out of an abundance of caution, as he began to have abdominal pain. The PCP said the facility did a PIP related to the incident and addressed the cause of the ingestion. He said if Resident #1 had ingested more drain cleaner he would have been in trouble, as it could have caused a hole through his esophagus or his stomach. CNA #1 was interviewed on [DATE] at 12:45 p.m. CNA #1 said on [DATE], she saw Resident #1 sitting in his wheelchair in the hallway drinking from a bottle that contained a chemical. CNA #1 said she took the bottle away from the resident. CNA #1 said she realized Resident #1 had drank some of the chemical when she noticed his lips and tongue were blue. She said she notified the charge nurse, and the charge nurse and PCP evaluated the resident. CNA #1 said the facility had all staff check the facility, including all residents' rooms for hazardous items, including chemicals, following the incident on [DATE]. CNA #1 said the facility provided inservice training after the incident for all staff, which included both in person and online training and included the need to ensure residents could not access hazardous items. The social services director (SSD) was interviewed on [DATE] at 9:30 a.m. The SSD said she received hazardous material training upon hire and again recently completed training in person and online after the incident involving Resident #1. The SSD said the training focused on the need to protect residents from hazardous items. The SSD said she was one of the staff members who were doing weekly rounds to check for any hazardous items. She said the extensive training post-incident for all staff helped to make the staff sensitive to the potential hazards that existed to residents.</p>		